STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center ● Bland Bryant Building
55 Wade Avenue ● Catonsville, Maryland 21228-4663
Martin O'Malley, Governor –Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

RE: Application for Renewal
Of Residential Service Agency Licensure

Enclosed is an application for renewal of your Residential Service Agency (RSA) license. Please submit your renewal application and licensure fee 30 days before your expiration date. If your license is not renewed before the expiration date, OHCQ will consider your agency terminated and Medicaid will be notified.

In accordance with the Code of Maryland Regulations 10.07.05, the following must be received by our office before a license can be issued:

1. The completed application, including the state affidavit.
2. A check or money order for $500.00 (non-refundable) made payable to the Department of Health and Mental Hygiene.
3. A list of licensed and non-licensed personnel. **Note: Certification is required for aides; be sure to include licensure verification for <u>all</u> licensed employees.** Identify the position held by non-licensed personnel.
4. Identify lead licensed personnel.
5. A list of all Medicaid programs that your company has contracts with.
6. **Any subsistent changes in your policies and procedures since last licensure cycle.**
7. Completion of the **Residential Service Agency (RSA) Annual Data Collection Survey.**

Please complete the entire application. Incomplete applications will be returned.

Return the above information to:

Office of Health Care Quality
Spring Grove Center
Bland Bryant Building
55 Wade Avenue
Baltimore, Maryland 21228
Attn: Elaine Horsey

If you do not intend to renew your license, you must return your operating license to this office.

Please be advised that an unannounced on-site inspection of your facility may be performed to determine compliance with the RSA requirements. If you are operating as an unlicensed RSA program, you are in jeopardy of termination of your Medicaid provider number and reimbursement.

PLEASE NOTE: OHCQ WILL NO LONGER HAVE CODE OF MARYLAND REGULATIONS (COMAR) AVAILABLE FOR PURCHASE. TO OBTAIN A COPY OF THE REGULATIONS YOU MAY DO ONE OF THE FOLLOWING:

- Visit the Division of State Documents website at www.dsd.state.md.us
- Call the Division of State Documents at 410-974-2486 ext. 3876 or 800-633-9657 ext. 3876
- Visit your local library (Check online at www.dsd.state.md.us/Depositories.aspx to find the closest location)

If you have questions regarding this notice, please contact Elaine Horsey at our Office at (410) 402-8267.

Sincerely,

Barbara Fagan
Program Manager
Ambulatory Care Programs
Office of Health Care Quality

BF/edh

Enclosure: Residential Service Agency Renewal Application

cc: Jane Wessley
Division of Nursing Services

OFFICE OF HEALTH CARE QUALITY
Residential Service Agency Renewal Application

THIS APPLICATION CANNOT BE USED TO PROVIDE SKILLED NURSING AND AIDES ONLY SERVICES

Under the provisions of Code of Maryland Regulations (COMAR) 10.07.05, application is hereby made to operate a Residential Service agency in the State of Maryland.

Official name of agency _____

Trading Name (dba) _____

Agency Address _____

_____ **County** _____

Mailing Address (if different from above) _____

_____

Business Phone No. _____ **Fax No.**_____

Email Address: _____

Days and Hours of Operation_____

Emergency/After Hours Phone Number_____

Administrator: **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ _____

See Page Three for information about Branch Offices.

A non-refundable application fee of five hundred dollars ($500.00) is to be attached to the application. Make checks or money orders payable to the Maryland Department of Health and Mental Hygiene.

Home Care Services to be provided:

Service Group One
_____Skilled Nursing only

OR

_____Skilled Nursing and one of the following:
(Select One)
_____Aides
_____Occupational Therapy
_____Physical Therapy
_____Speech Therapy
_____Medical Social Services
_____Intravenous or Related Therapies
_____Durable Medical Equipment
_____Durable Medical Equipment w/Oxygen
_____Ventilator Services

Service Group Two
_____Intravenous or Related Therapies only

Service Group Three
_____Ventilator Services only

Service Group Four
_____Durable Medical Equipment Only

Service Group Five
_____Durable Medical Equipment w/Oxygen

Category: For Profit ( ) Non Profit ( )

Type of Ownership:

□ **Individual/Sole Proprietorship**

Name of Owner_____

Address of Owner_____

□ **Partnership** □**Corporation**

If the applicant is a corporation, or partnership, list each officer or director, and the names of individuals holding 2% or more ownership. (Attach list if necessary)

Name & Title	Address	%Owned
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Branch Office

If applicable, list address (es) of any branch office (s):

_____

_____

_____

Note: "Branch office" means a satellite office of a RSA that is operated by the same person, corporation or other business entity that manages parent RSA, and that along with the parent RSA has the same:

a. Ownership tax identification number as the parent business entity;
b. Upper-level management;
c. Policies and procedures; and
d. Provides services within the same geographic area served by the parent business entity.

"I, _____, do solemnly declare and affirm under penalties of perjury that the contents of the foregoing application are true to the best of my knowledge, information, and belief. I understand that the falsification of an application for a license shall subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the Department of Health and Mental Hygiene. "

_____
Print Name of Authorized Person

_____
Signature of Authorized Person

_____
Title

_____
Date

By signing this form, the signee indicates full understanding that a violation will constitute grounds for revoking the license to operate a Residential Service Agency in the State of Maryland.

STATE AFFIDAVIT

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable State Laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that this agency is in compliance with the administrative and procedural requirements pertaining to COMAR 10.07.05, Regulations governing RSA Agencies, in the areas of written administrative patient care policies and other organizational documentation.

I further certify that I will notify the Office of Health Care Quality if there are any future substantive changes in agency and operation that significantly affect policies and procedure that notice will be given, in writing, before the effective date of the change.

I hereby swear and affirm that I am over the age of 21, I am otherwise competent to sign this Affidavit, and that these statements are true and based upon my personal knowledge.

NAME OF AGENCY: _____

_____

SIGNATURE OF AUTHORIZED OFFICIAL TITLE DATE

Residential Service Agency (RSA) Annual Data Collection Survey

1. **Current Residential Service Agency (RSA) License No._____**
   Licensed Name _____
   Street: _____
   City/State: _____
   Zip Code: _____ Area Code/Telephone: _____

   Contact Person: _____ Title: _____
   Person Completing Survey: _____
   Date Survey Completed: _____ Phone: _____

2. **The requested information reported in this survey is for the past 12-month period.**

   Beginning Date: ___ ___ ___ ___ ___ ___ ___ ___
   Month Day Year

   Ending Date: ___ ___ ___ ___ ___ ___ ___ ___
   Month Day Year

Note: If you are <u>not</u> reporting data for a complete 12-month period, select the appropriate response:

Newly established RSA ____ RSA Closed ____ Change in Ownership ____
Other: _____

3. **Which of the following services were consistently provided to clients by your RSA staff during this 12-month period? Please check appropriate boxes.**

Services Provided	Yes	No
Skilled Nursing		
Personal Care Services		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Homemaker/Chore		
Transportation		
Laboratory		
Intravenous or Related Therapies		
Medical Social work		
Ventilator Services		
Dietary and Nutritional Consultation		
Durable Medical Equipment		
Oxygen		
Other (specify):		
Other (specify):		
Other (specify):		

4. **Report the Number of Full Time and Part Time employees for Administrative/ Support staff, Direct Care Personnel, Drivers, Maintenance Techs, and Supervisor Personnel during this 12-month period. Include independent contractors under agreement with your agency.**

Type of Personnel	Full Time Personnel	Part Time Personnel
Administrative Personnel		
Registered Nurses (RNs)		
Licensed Practical Nurses (LPNs)		
Certified Nurse Aides (CNAs)		
Geriatric Nurse Aides (GNA)		
Medication Technician		
Physical Therapists (PT)		
Occupational Therapists (OT)		
Speech Therapists (ST)		
Respiratory Therapists (RT)		
Home Health Aides		
Medical Social Workers (MSW)		
Homemakers		
Companion		
Driver		
Other:		
TOTAL		

The numerical responses to questions 5 thru 11 should not include companion care clients or clients provided services outside of the State of Maryland.

Key:

Group A.) Patients that require care from a RN, LPN, PT, OT, ST, RT, MSW, etc.

Group B.) Patients that require an assessment from a Registered Nurse but receives care from a CNA, GNA, Aide, Med Tech, etc.

Group C.) Durable Medical Equipment/Oxygen Clients

5. **Report the Total Number of Admissions in the 12 month period:**
   Group A _____ Group B _____ Group C _____

6. **Report the Total Number of Discharges in the 12 month period:**
   Group A _____ Group B _____ Group C _____

7. **List the agency's current census: _____**

8. Please provide the number of clients in Each Jurisdiction for Which Your RSA Provided Services to Clients During this reporting period. Refer to question 5 for difference between Group A and Group B.

Jurisdiction	Enter The Number Of Group A Clients That Your Company Provided Services To Within The Appropriated Age Group						Enter The Number Of Group B Clients That Your Company Provided Services To Within The Appropriated Age Group					
	0-14	15-44	45-64	65-74	75-84	85+	0-14	15-44	45-64	65-74	75-84	85+
Allegany County												
Anne Arundel Co.												
Baltimore County												
Calvert County												
Caroline County												
Carroll County												
Cecil County												
Charles County												
Dorchester County												
Frederick County												
Garrett County												
Harford County												
Howard County												
Kent County												
Montgomery Co.												
Prince George's Co.												
Queen Anne's Co.												
Somerset County												
St. Mary's County												
Talbot County												
Washington County												
Wicomico County												
Worcester County												
Baltimore City												
TOTAL												

9. Please provide the number of Group C (DME/Oxygen) clients in Each Jurisdiction for Which Your RSA Provided Services to Clients During this reporting period. (if applicable)

Jurisdiction	Number of Clients	Jurisdiction	Number of Clients
Allegany County		Harford County	
Anne Arundel Co.		Howard County	
Baltimore City		Kent County	
Baltimore County		Montgomery Co.	
Calvert County		Prince George's Co.	
Caroline County		Queen Anne's Co.	
Carroll County		Somerset County	
Cecil County		St. Mary's County	
Charles County		Talbot County	
Dorchester County		Washington County	
Frederick County		Wicomico County	
Garrett County		Worcester County	
TOTAL			

10. Are you licensed or provide care in any other State or in the District? _____
If yes, please list (attach additional pages if needed):

_____

_____

11A Report the Number of Clients Served During this Reporting Period by Payer Source

Payer Source	Number of RSA Clients
*Medicaid	
*Other Government	
Private Insurers	
HMO/Managed Care	
Self Pay	
*Other State Program, Please specify:	
Other, Please specify:	
Unknown	
	TOTAL Clients =

***If RSA clients are from a State Program (Medicaid, Department of Aging, Department of Human Resource, etc.), report the specific Maryland State Program and appropriate contact person with phone number, below:**

B.) Report the Specific Maryland State Program with Contact Information (for additional programs, attach separate sheet)

Specific Maryland State Program	Name of Contact Person	Phone Number/E-mail

Revised 10/10